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Organizational blind spots: splitting, blame and idealization in the National Health Service

Marianna Fotaki and Paula Hyde

Abstract

The paper examines the escalation of commitment to failing strategies from a psychodynamic perspective as an affective process connecting organizational, systemic and individual levels. We propose a theory of organizational blind spots to explain how such escalation of commitment occurs. Blind spots develop an organizational defence mechanism for coping with problems resulting from attempts to implement unrealistic strategy or policy goals. Unrealistic strategic aims mobilize and reinforce blind spots through processes of splitting, blame and idealization, thus enabling organizations to persist with unsuccessful courses of action. Organizational blind spots arise when leadership and/or operational members in organizations are unable to acknowledge unworkable strategies. Vignettes from the National Health Service in England (the NHS) are used to illustrate how blind spots sustain an illusory possibility of success while commitment to a failing strategy escalates. The theory of blind spots offers a novel social-psychological approach to understanding how these dysfunctions of strategy develop and become institutionalized, putting organizations in jeopardy and threatening their survival.

Keywords

organizational blind spots, blame, escalation of commitment, idealization, public policy, social defences, splitting

Introduction

When decision-makers commit to failing strategies, the impact is far reaching, affecting customers, employees, taxpayers and/or citizens (Staw, 1981; Brockner, 1992; Bazerman & Neal, 1992; Keil et al., 2000). Various theoretical frames have been used to explain these phenomena including expectancy theory (Vroom, 1964), self-justification (Brockner, 1992), risk-taking (Keil et al., 2000) and prospect theory (Kahneman & Tversky, 1979). These theories advance two broad types of explanation: (a) the minimization of risk through perception bias and (b) the psychological inability of actors to accept previously incurred losses. While such approaches offer important insights into the mechanisms and dynamics of the emergence of escalation of commitment, questions remain as to why rational individuals continue to invest their time and energy in pursuing unsuccessful strategies. Mainstream economics acknowledges people may not act in accordance with their objective needs or behave rationally (Thaler & Sunstein, 2008). Equally, the importance of affect in decision-making leading to the build-up of the escalation spiral has also been recognized (e.g. Wong & Kwong, 2007). However, there is a dearth of research into social and structural determinants of escalation of commitment (Ross & Staw, 1993; Sleesman et al., 2012:557).

In response, we draw on a body of work concerned with social defences against anxiety to elaborate further the phenomenon of escalation of commitment. We develop the concept of “organizational blind spots” to describe how defence mechanisms enable organizations to remain committed to unworkable strategies, arguing that the formation of blind spots is a result of a dual process. First, we suggest that blind spots are fueled by unrealistic policies emerging in response to unconscious social demands, such as the expectation that health systems, when run properly, can prevent disease and dying (Obhlozer, 1994). Second, we suggest that blind spots are enabled by defence mechanisms (splitting, blame and

idealization), that play a role in maintaining commitment to unsuccessful strategies. Three cases from the National Health Service (NHS) in England provide exemplars of the dynamics that lead to the development and institutionalization of blind spots.

Thus our contribution in this paper is threefold. First, we indicate the potential for a psychoanalytic lens to deepen understanding of commitment to failing strategies in organizations by highlighting the dynamic interplay between affect, cognition and unconscious motivation. The second contribution builds on Menzies (1960) work on social defences to describe the evolution and maintenance of organizational blind spots through interactions of individual defences with organizational and social contexts. The third and final contribution is the extension of the literature by linking escalation of commitment phenomena to individual and organizational dynamics and systemic policy.

To develop our argument we, first, briefly review existing work on escalation of commitment. These ideas are then examined through a psychodynamic lens to elucidate the evolution of organizational blind spots. Three constituent processes of splitting, blame and idealization are identified as mechanisms enabling escalation of commitment. We illustrate how these defences allow for splits between strategy (policy) and operations (implementation) to occur, thus distancing decision-makers from the results of their decisions and permitting them to blame operational members for any failures. Subsequent sections present examples from health service and health policy, illustrating the development and institutionalization of organizational blind spots through these defensive mechanisms. In conclusion, we discuss how organizations might protect themselves from the pitfalls of escalation.

Committed to failure

Organizational research offers many accounts of why organizations remain committed to failing strategies (Staw & Ross, 1986; Brockner, 1992; Ross & Staw, 1993; Staw et al., 1997; Lunenburg, 2010; Sinha et al., 2012). Pioneering work by Barry Staw demonstrates people escalate commitment to failing strategies in spite of the ‘objective facts of the situation’ in the hope of recouping previous losses (Staw, 1981:584). Staw describes a cycle of escalating commitment that is produced as more resources are used in the hope of recouping previous losses. He also argues escalation of commitment depends, to some extent, upon who is blamed for previous losses with escalation decisions based at least in part on the actors’ perceived personal responsibility for losses and political vulnerability. Related studies also argue that there are less than rational motivations to continue investing in a project beyond any possibility of recuperating the incurred costs (e.g. Brazerman & Neal, 2000).

Various other explanations point at influential factors including: problem framing (Whyte, 1986), self-justification (Brockner, 1992), the illusion of (Staw et al., 1997), and imperative to, maintain control (Sinha et al., 2012) or the motivation to reduce future regret under escalation situations (Wong & Kwong, 2007). The evaluation of the possibility of an adverse outcome and/or the perception of risk is crucial in risk-taking theory, which argues that the disutility caused by losses is greater than the utility obtained from equivalent gains (Kahneman & Tversky, 1979). In self-justification theory, for instance, aversion to accepting loss is decisive (Brockner, 1992). It has also been noted that the sunk cost (Keil et al., 2000) creates a cognitive bias at a subconscious level, prompting decision makers to take further risks. In other words, individuals’ escalation tendencies are a function of negative affect suggesting that people seek to escape from the unpleasant emotions associated with escalation situations. This is consistent with the predictions derived from the coping

perspective (Wong et al., 2006). Further, Wong and Kwong (2007) specify that the emotions people expect to experience in the future (e.g., anticipated regret) and the events that have happened in the past (e.g. responsibility for initiating the previous decision) simultaneously influence their decision in escalation situations. However, these ideas frequently refer to escalation of commitment at an individual level whilst such processes often occur in organizational and wider societal contexts (see Staw & Fox, 1979; Ross & Staw, 1993). For instance, as Staw & Fox (1979) show, external justification effects are particularly strong among those who are politically vulnerable or whose initial policy choice has met with resistance. Further, the binding of decision makers to a course of action is especially strong when advocacy is public, explicit, high in volition, and repeated (Salancik, 1977 cited in Ross & Staw, 1993). A more recent meta-analysis of 166 empirical articles by Sleesman et al. (2012) identified several different factors influencing the decision to escalate commitment to a failing course of action, which they categorized as project-related, individual (psychological) and structural (social) issues.

Yet despite explicit references to the importance of context in the literature on the escalation of commitment (Sleesman et al., 2012), the majority of explanations continue to focus on individual rather than organizational or social factors, and on cognitive rather than emotional aspects of decision making. To address gaps in the existing research on the escalation of commitment, we turn to the disciplines interpreting individual psychological process in a social context and take account of the unexplored dimensions of affective attachments to failing projects.

The evolution of organizational blind spots: Splitting, blame and idealization

Psychoanalysis may offer a valuable method to explore unconscious aspects of escalation of commitment which occur as individuals interact with organizational and social structures through various psychological mechanisms. Psychoanalytic theories acknowledge individual tendencies for self-deception, which originate in the desire to repress undesirable feelings and/or realities. Object relations theory (Klein 1952) suggests self-deception processes involve projecting the unwanted aspects of self onto other objects/people/groups (Klein, 1952). Klein's original concept was based on observations of infants and described defences which protected babies from the unpleasant emotions related to vulnerability, including fear of abandonment and physical sensations of hunger. While psychological defences are often indispensable for survival and can initially reduce anxiety, they are often achieved by distorting reality.

Isabel Menzies (1960) built on the concept of the 'social defence' against anxiety originally developed by Elliot Jacques (1956), to refocus attention from the individual to an organizational level. Menzies described socially sustained defence mechanisms occurring in response to anxiety evoked by the specific work task - in her case the fear of death experienced by nurses and avoidance of proximity to suffering patients. Her theorizing was helpful in explaining why organizations develop defences and how these could be deployed to reduce work-related anxiety through depersonalization of care, avoidance of responsibility and a slavish attention to routines and rituals (Menzies, 1960). Such distortions, for instance involving nurses waking up patients so they could be given sleeping pills, were seemingly unrelated to the primary task of the organization but were an effect of 'historical development in nursing services through collusive interaction of individuals to project and reify relevant elements of their psychic defence systems' (Menzies, 1960:115). Building on this work,

Lawrence (1986) extended the idea of primary organizational task as the *essential* aspect of what an organization does, and needs to keep doing if it is going to continue to exist in its current form, to include three further aspects that were unrelated to it but often appeared in organizations as defensive mechanisms. These comprised the 'normative' task, referring to a set of publicly stated goals; the 'existential' task expressing the beliefs and values of those working in the organization and 'phenomenal' task, which was usually unconscious having to do with deeper psychic needs of the organizational members (Lawrence, 1986:59). While these defences may be protective in certain instances offering containment, and providing opportunities for group identification (Brown & Starkey, 2000; Petriglieri & Petriglieri, 2010) they exceed their usefulness when their maintenance becomes the focus for organizational work.

The following sub-sections outline the three psychological defence mechanisms of splitting, blame and idealization originally derived from Klein and Menzies' objects relation theory. We explain how these mechanisms contribute to the development of organizational blind spots, before outlining a theory of the evolution of blind spots in organizations.

Splitting

The psychological notion of 'splitting' refers to a defence that is used by people to cope with doubts, conflicting feelings and anxiety. Splitting enables the individual to separate negative and positive feelings (Krantz & Gilmore, 1990:189). When splitting occurs, objects are not recognized as wholes, but as separate 'part' objects, with the 'good' part being idealized and the 'bad' part carrying the potential to cause harm (Klein, 1952). In periods of extreme stress, adults may regress to a developmentally earlier state of splitting and projecting bad objects in order to temporarily relieve anxiety. The idealization of wholly good objects and blame of

wholly bad objects associated with splitting, when overused, may enable detachment from reality. Although defences aid survival, they also create difficulties because they do not resolve the original source of anxiety and further anxiety is generated from fear of attack from the 'bad' object. When this occurs, splitting results in a spiral of increasing threats and reduced capacity to deal with such threats effectively. As a result, it becomes increasingly difficult to challenge as any resolution involves the reintegration of unpleasant elements.

Splitting also occurs between emotions and rational aspects of managing change in organizations (Vince & Broussine, 1996), and between elements of organizational learning which threaten collective identities (Brown & Starkey, 2000). Krantz & Gilmore (1990) researched splitting between management and leadership, which involved the simultaneous projection of idealized aspects of leadership on true but distant leaders, and the devaluation of leadership's undesirable features by projecting them onto managers who are responsible for the day to day operations. These unconscious and socially sanctioned mechanisms can become embedded in organizational structures and cultures, obscuring problems and interfering with project implementation. This occurs when problems may be too difficult and painful to confront and established organizational practices may be too precious to forsake. In order to defend against realization, the problems are then projected onto the departments or people who are wrongly identified as being problematic. Denial and displacement of unworkable strategies leads to the creation of organizational blind spots and the ultimate failure of projects or the entire organization.

For example, in the case of the Challenger space shuttle disaster, propulsion engineers felt unable to report erosion of the O-ring seals, whilst managers reported that engineers could tell them anything. These two disparate and opposing views, held by managers and engineers

both appeared to be genuinely believed (Gabriel, 1999:2-5). Managers saw engineers as overcautious and, rather than carrying a warning, the technicians came to be seen as the problem itself (Hirschhorn, 1988). According to the psychodynamic perspective, NASA managers needed to protect themselves against the real or perceived threat from the bad objects identified as the technicians, and achieved this by unconsciously restricting the means through which technicians could communicate with them. The risk of failure for the top administration was 1 in 100,000, but the engineers and statisticians estimated it as 1 in 200 to 1 in 300 (Schwartz, 1990:89). As a result, the technicians found it increasingly difficult to raise concerns and each successful launch was taken as evidence by managers against the dangers predicted by technicians (Vaughan, 1996) while the organization sought to contain the problem.

Blame

While splitting allows for the generation of blind spots, blame allows the split to be sustained and often follows or accompanies splitting. As a result of splitting, certain parts of the organization may appear to be made up of difficult members; they are then regarded as having always been difficult and are therefore held responsible for their own problems as the case of Challenger disaster illustrates. In psychodynamic theory, blame involves projecting unwanted parts of the undesirable situation onto other people or things because an external conflict is preferable to the consequences of having to engage in self-examination. The act of blaming is indispensable for rationalizing failure away by identifying a suitable culprit: either an individual or group of individuals or even a menacing bad policy or strategy that threatens the organization from the outside. Whilst externalization of bad feelings offers a superficial and short lived comfort, it also renders the organization blind to those who might help overcome problems. Blame is generally seen as problematic in organizations: it can be

mistakenly and unconsciously attributed to those who identify organizational problems. As Klein (1952) describes, such 'part objects' generate bad feelings and pose a threat to the ideal state, and, as such, they must be defended against. The escalation of blame is then required to maintain its 'protective' role in enabling flight from organizational reality and to sustain idealization at an individual, organizational and/or systemic level as follows.

Idealization

Holding ideals is not in itself problematic. Both the ego-ideal (an aspect of self-based on internalized values, norms and images especially, those of parents and peers, one admires and wishes to emulate, Gabriel, 1999) and the organizational ideal (where desirable attitudes, imagined attributes and aspirational wishes of organization are internalized by its members, Schwartz, 1987:330), refer to unconscious strivings towards what one is supposed to be. In themselves, they are unproblematic directional indicators: in offering vision they provide impetus and motivation for action. However, problems arise when an idealized (individual or organizational) state is thought to have been achieved because critical reflection and questioning then become impossible. Brown & Starkey (2000:106) argue that idealization may be necessary for maintaining a sense of organizational identity; but it is nonetheless dysfunctional because it militates against rational and realistic organizational decision-making. Criticism is then believed to arise from the malicious intent of others and needs defending against. Such idealization is only superficially comforting as it maintains contact with good, albeit unrealistic, feelings whilst bad feelings are externalized.

Certain organizations and their members are especially susceptible to idealization. In these instances, idealization shifts to the systemic level as the purposes that institutions embody become the object of emotional investment. Hence, in the Challenger case, the scientists

(engineers) were mistaken for the problem as their concerns were received as malicious criticism that required defending against. The ideal that needed to be maintained in the case of Challenger was that of the superiority of US science while, in reality, US research institutions operated under a regime of acute spending cuts (Hirschhorn, 1988). Large public institutions tend towards idealism because they perform particular social functions by allowing citizens to project onto them their aspirations (Hoggett, 2006) and unconscious desires allied with primitive fears of survival (Obholzer, 1994, Fotaki, 2006). This applies equally to systems charged with health care, education and criminal justice (De Board, 1978; Illich, 2002). In sum, splitting and blame together support and enable idealization while all three mechanisms jointly contribute to the creation of blind spots as is explained below.

Development of a theory of the evolution of organizational blind spots

We develop the concept of organizational blind spots to explain how individual psychic processes of idealization, splitting, and blame contribute to the creation of social defences operating at group and organizational levels and how they may be reinforced further by the wider social environment and expressed through aspirational policies and unrealistic strategies. These mechanisms are, however, invariably sustained and reproduced by individuals or groups. Psychoanalytic ideas envisage the possibility that individuals can deceive themselves without lying or being disingenuous. Repression allows for the prevention of dangerous or unpleasant ideas from reaching consciousness so they become restricted to an unconscious part of the mind (Gabriel, 1999:5). This compartmentalization may be necessary as the excessive anticipation of negative outcomes may threaten the ability for creative action. As was explained above, splitting is the first step in the development of organizational blind spots.

The concept of organizational blind spots does not merely refer to a pervasive state of denial of reality but is about the institutionalization of such denial through organizational rituals, routines and storytelling. In addition, affective mechanisms are often employed to fulfill organizational members' unconscious need to obscure a painful reality that might otherwise threaten their ego and/or organizational ideal, as in the example of the Challenger standing in for the achievements of US science. According to Lawrence's terminology, NASA emphasized performing its normative and phenomenal tasks at the expense of its primary function. This led to the development of a dysfunctional organization in the mind of its members (Armstrong, 2005), which was then shared and jointly reproduced, despite some individuals or groups in the organization being fully aware of the ensuing negative outcomes. Yet, the organization remained blinded to its protective mechanisms by isolating those organizational members (e.g. engineers in the case of Challenger or the health care staff in the subsequent examples) who drew attention to problems.

In refusing to acknowledge failings, organizational members or groups detach the bad feelings stemming from failure and project them into other objects. This allows the organization to continue escalating commitment to unworkable strategies. However, when reality catches up, the response is either to integrate the alleged 'doomsayers' into the process of decision making or an even more excessive splitting and apportioning of blame. Responsibility (blame) for failure, then, may be transferred externally (onto other institutions/policies) and internally (to other parts of the organization). Such defences, operating throughout organizational systems offer the potential for increased risks as procedures may subsume rational decision-making and systems can then fail to achieve desired goals. This can generate a spiral of increasing demand, thus reducing the effectiveness of social institutions (Illich, 2002) and causing inefficiencies in organizations

that implement them. Socially structured defences can ultimately lead to absurdities as the need to defend against anxiety supersedes rationality and their usefulness in fulfilling the organizational task.

We next discuss three vignettes illustrating the development and institutionalization of organizational blind spots in health care organizations, set in one of the largest and most admired public service institutions, the National Health Service (NHS) in England.

Organizational blind spots: Three NHS exemplars

The first two examples are derived from secondary published sources. In the third example, we offer a glimpse of an organizational ethnography conducted in a mental health ward. These examples cover investment in information technology (IT) development, patient choice policy and attempted reforms of mental health care. Each of them focuses specifically on blindness to failure through splitting, blame and idealization. While these are separate cases they share a number of common features and taken together they provide insight into the development and institutionalization of blind spots.

Example 1: National IT programme for the NHS

The UK government is particularly vulnerable to escalating commitment to health policies as it carries responsibility for large-scale investment decisions in the NHS that are expected to achieve improvements in health care. Between 1999 and 2001, £214m in central funding was allocated to modernizing information technology in the NHS to achieve a nationally compatible records system; however, much of the money was diverted to meet more urgent needs (Carnell, 2001). In response to this initial failure to secure funds significant further investment was identified to develop a national IT system for the NHS. This programme,

proclaimed to be the biggest investment ever (Brennan, 2005), was rapidly idealized as it promised a solution to co-ordination problems in the NHS. The project aimed to connect 30,000 general practitioners to 330 hospitals and cover the records of tens of millions of patients in England (Northern Ireland, Scotland and Wales opted out of this IT ‘Spine’ project).

This unprecedented investment in a national records system in the NHS was the world’s largest civil information technology (IT) project (Brennan, 2005) aiming to electronically store patient records into a common user interface that would improve efficiency and patient safety (Coiera, 2007). By 2002, planned investment had soared considerably as had the scope of the project. New investment was designed to provide an integrated IT system including: prescription service, bookings service, and lifelong health records. The plan was to spend £6.2bn on designing and providing this system. This figure, by the government’s own estimates, rose to £6.8bn by 2006. However, the National Audit Office estimated the total bill for the program would run to £12.7bn and could be closer to £20bn if spending on established networks was included (National Audit Office, 2006). Media and academic sources sought to question the likelihood of success given the widely recognized difficulties of developing large scale public information systems (Goldfinch, 2007). In addition, the program was criticized, by doctors, on two fronts: that there was secrecy in the tendering process about what the program was supposed to deliver; and proposed plans to share records would breach medical privacy and other human rights and, therefore, be illegal according to UK law (Cross, 2006). Doctors questioned the scope of the project but were largely excluded from consultations or evaluations of the project as it became mired in legal controversy and continued to lack the support of clinicians. Ability to assess progress of the project was complicated by the awarding of contracts for various parts of the IT system to different

companies so that, for example, when the system allowing patients to choose providers and book appointment times through general practitioners, was delivered on time (Department of Health, 2004), it could not be properly tested because the care records system on which it depended was running late.

There was an escalation of commitment as increased spending was allocated to the project, which had achieved few results and for which substantial funds had already been committed. While escalation of commitment can occur with any type of project, software projects may be particularly susceptible because of the difficulty in assessing nearness to completion of the project (Keil et al., 2000). In large IT projects it is groups rather than individuals who may yield to escalation of commitment tendencies (Keil et al., 2000), especially if they are distanced from the reality of the task at hand. Fundamental issues concerning clinical knowledge and consultation, adequate procurement procedures and patients' anxieties concerning data protection were not sufficiently taken into account giving rise to the creation of blind spots during implementation of this IT project.

In this instance, the underlying aspiration was for controllability through information management and the necessary step towards the creation of blind spots, here, was the push to invest in the scheme without consulting or collaborating with clinical staff or learning from past failures (Goldfinch, 2007). A crucial factor was that those involved in the program of investment were physically split off and isolated from those who implement the system. Clinicians who pointed out the magnitude of socio-cultural shift that was required to make the project possible (Hendy et al., 2005), and who attempted to raise concerns early (Cross, 2006), were blamed as diehards for not embracing the much needed change. They were not involved in the early planning process, having already been identified as generally resistant to

changes in national health policy. The operational staff could have readily pointed to the legal and technical obstacles to sharing data but there was a separation of professionals into evaluative categories as visionaries and doers. The lack of detailed information about what the system was supposed to provide offered a blank slate against which policy makers and the public could project their aspirations. The absence of critically important information such as the legal difficulties of data sharing was partly due to the exclusion of groups that could provide it (i.e. the clinicians) and partly due to a failure to question the lack of detail about the scope of the project. Attention to either of these points could have allowed for a more judicious evaluation of the projects' future prospects.

The prominence and the political importance of the project meant that any uncertainty around it generated discomfort, which in turn stimulated defence mechanisms. The potential for the project to solve future health care problems was idealized and there was splitting off of the undesirable realities related to the complexity of the task and difficulties of implementation by blaming doctors and clinicians for being unhelpful. These expectations by policy makers, and their belief in IT were, we suggest, also held by the public and had to do with the idea that massive investments in technology could bypass 'messy' issues and, for example, deal with disease and dying. This allowed for the development of an ever increasing spiral of commitment necessary to maintain the idealization, sustained by structural splits between policy makers and those who could question the system. The enacted splits between policy makers and clinicians meant that the potential of the IT programme could become idealized and only came into question during attempts to implement parts of the system. Clinicians, were only included in the process once it hit difficulties (Cross, 2006). The project was abandoned in 2011 after the National Audit Office cast serious doubt on the wisdom of plowing further money into the scheme (Guardian, 2011).

Example 2: Individualized patient choice and personalized services

The second case also concerns national policy aimed at providing better health services, namely that of giving patients freedom of choice. The UK Government introduced patient choice policies to enable NHS patients to participate directly in decisions about time, location and the type of treatment they received (Department of Health, 2003). Individual choice was presented as a means for achieving diverse public policy objectives, including better quality and responsiveness to users' needs, increased efficiency and more equitable access to health services (Milburn, 2003). It was also presented as a 'good' in its own right (Le Grand, 2007). Ministerial speeches referred to the necessity and inevitability of radical changes:

We live in a consumer age. People demand services tailor made to their individual needs. Ours is the informed and inquiring society. People expect choice and demand quality (Milburn, 2002).

Whilst elements of the policy displayed inherent contradictions, such as seeking to increase both inter-organizational competition and collaboration, choice, at least on the surface, would seem more straightforward – those services chosen by the public would survive and develop.

However, to date, choice has not proven to be a particularly successful strategy. As past and more recent attempts to re-introduce this policy in the UK have shown, patients do not seem strongly attracted to the idea of consumerist market choice in health care (Fotaki, 2006). Thus a recent review of choice in public services found that only 35% of patients exercised choice of hospitals (Boyle, 2013). What mattered more to patients was obtaining information about their treatment (Picker Europe, 2007). Although generally positive about having choices, the most important aspects from patients' points of view concerned their involvement in

treatments rather than hospitals or providers (Coulter, 2010). In reality, patients were able to choose between hospitals and appointment times rather than primary doctors, hospital consultants and treatments. The ability of a patient-consumer to assess the quality of medical services received is for many types of treatment limited to such relatively peripheral issues as waiting time, comfort of waiting rooms and wards, and friendliness of staff, which they can use as a proxy for information to exercise choice. Contrary to policy makers' assumptions, patients prefer to delegate clinical decisions to a knowledgeable and trusted medical professional, perhaps in order to not experience anxiety or regret (Ryan, 1994) as to whether they are taking the right decision especially in the case of life-threatening and complex procedures (Fotaki et al., 2008). Hence, choice seems to be valued much less by patients when compared with availability of good quality local services (Coulter, 2005). Overall, it seems that patients were not particularly interested in the choices policymakers wanted them to make and policymakers were not providing what mattered to patients.

Furthermore, although individual patient choice policy was introduced to serve 'the needs of many and not the articulate few' (Milburn, 2003), it is not compatible with the goals of public health systems (Oliver & Evans, 2005) because not all groups of patients are able to exercise choice in an equal measure (Burge et al., 2005). Personalized choices are in conflict with the collective goals of public health systems (equity and efficiency) as more resources are likely to be needed to meet individualized patients' wants at the expense of equal availability of services to all. The effects of the earlier pro-market reforms on improving efficiency were also questioned (Le Grand et al., 1998). More importantly, patients' need for relational aspects of care (Mol, 2008), that do not easily fit with consumerist ethos of the market choice, is disregarded.

Yet despite the evidence of a moderate success and relatively limited uptake of choice by patients, giving individual opportunities to decide about secondary aspects of services is popular with policy makers (author/s). This, we propose, is because choice is a concept susceptible to idealization as it evokes a fulfilling ideal of unlimited freedom; who, after all, can be against choice? However, it is the denial of limitations to choice and the inevitable trade-offs (between choice and equity and quality and efficiency for instance) that lies at the heart of idealization in patient choice policy. Idealization obscures the reality of such limitations and enables the creation of blind spots. The relatively low importance of choice for patients and the costs entailed in these reforms is side-stepped by projecting idealized expectations onto a specific policy which cannot be fulfilled. When expected effects go unrealized maintenance of the strategy may have to rely on the separation of the ‘good’ traits of the idealized policy, while insignificant shifts are proclaimed to be major breakthroughs (Pollock et al., 2011). Negative aspects of such policies are projected into external objects (i.e. incompetent managers, see Le Grand, 2003 or ‘unreformable’ and/or recalcitrant health professionals, see National Audit Office, 2005). Such splitting is a necessary mechanism for idealization to continue.

However, it is not only policymakers who are blinded by policy idealization while those trying to make the reforms work face difficulty. Policies are also a product of social fantasy, expressing unconsciously held and collectively expressed longings (Fotaki, 2010:7):

‘Because freedom of choice stands for (an illusory) freedom from the bounds of human predicament, the finitude of life and failure, it is an attractive proposition for the patients who can escape the reality of being ill and cared for, and for policy makers who can hope to make a lasting difference with a few additional resources’.

One of the important tasks of public organizations is to encompass the unresolved (and often partially suppressed) value conflicts and moral ambivalence of society while the fate of the public official is to both express and contain it (Hoggett, 2006). In reality, many actors may be implicated in a dynamic that serves the unconscious needs of politicians and those of the public and users of services or even some professional groups, on whose behalf politicians work – and make policy. Since idealized expectations of choice cannot be realistically fulfilled through policy objectives, likely failure can easily unleash blaming of managers or clinicians and sometimes even extend to patients, as the final example illustrates.

Example 3: Mental health service reform

Mental health services have been subject to almost continuous reform since the introduction of community care and the closure of large asylums in the 1980s (Beresford et al., 2010). The idea of community-based mental health care is that people could be cared for at home except in exceptional circumstances. Following mass disinvestment in large institutions in England, the need remained for in-patient psychiatric beds which were often provided in small units on acute hospital sites.

The case described here relates care provided in one of such settings, focusing on the ongoing difficulties experienced by those providing services on a psychiatric ward in one such acute hospital in the North West of England with few resources to do so. Although it presents details of one ward, the conditions described are not dissimilar to other psychiatric wards throughout England (Willshire, 1999). The ethnographic case study from which this example derives involved spending long periods on a psychiatric ward, observing and talking to staff and patients and trying to understand and interpret their experiences of organizational life.

Fieldwork on the ward took place over six weeks and involved over 100 hours of non-participant observation. In addition, staff and patients were interviewed.

The psychiatric ward continuously operated at around 112% capacity, normally having 26 severely mentally ill patients admitted to the ward and only 22 beds. The nursing staff had little control over who was admitted to the ward but had to find ways to accommodate new patients. They did so by sending patients home on leave in the hope that they could stay there until a bed became free again – their bed having been filled by an emergency admission. The physical and emotional demands of the work often threatened to overwhelm the staff as they were tasked with ensuring not only the well-being of the patients but the safety of the public at large by preventing harm from and to patients even when they were not on the ward.

Social defences in a mental hospital can take the form of peculiar splitting whereby madness remains with the patients and sanity with the staff. Rigid barriers are then required to prevent contamination. These barriers can prevent the restoration of patients to a degree of health via their reclamation of sanity (Hinshelwood & Skogstad, 2000). In this instance, there was an additional aspect involving the idealization of reforms aiming to provide care in the community, which as was underpinned by the unconscious wish that this might contain and/or eradicate madness. The empirical vignette shows that there were no real means for offering adequate care for patients who had to be institutionalized even temporarily and those could not be provided for in the community.

The ward environment was highly charged as the staff were working double-shifts, struggling to complete all tasks and finding themselves unable to meet the demands made of them. In addition, much of the equipment on the ward was broken and there were constant struggles to

obtain even basic equipment such as functional telephones, televisions and kitchen equipment. These privations in psychiatric services are almost endemic and date back many years (Bott-Spillius, 1990). These demands were impossible to meet in two senses; first, there were not enough resources to care for the patients and second, there was no means of eliminating madness. To defend against the anxiety generated by the impossibility of the work there were many splits in the system; managers blamed staff for being inefficient, staff blamed patients for being overly demanding. This extract from the original case study gives one example:

The unit manager was accommodated in a room adjacent to the ward but her description of the ward environment bore little resemblance to what I saw. She blamed the staff for the ward conditions. The staff blamed the patients for their constant requests to have doors unlocked or to gain access to parts of the ward such as the kitchen, bathrooms and activity room. One example of this misplaced blame concerned the ward milk supply. Each day 40 pints of milk were delivered for 22 patients. The majority of this milk was removed by other people whom the ward staff let onto the ward – cleaners, builders etc. However, the constant shortage of milk was attributed to the patients who were described by staff as ‘greedy’, ‘selfish’ and ‘demanding’. To compensate for the constant shortage of milk a relative brought in a four pint container of milk for her son. When the relative approached a nurse to ask where the milk had gone to, the nurse replied; ‘It will have been drunk by the others’. A nurse says very quietly ‘it’s in the OT kitchen’. Eventually the keys are found and the milk is obtained. (Case study analysis)

Blame was displaced from one person to another with staff taking their frustration out on the patients, for example by thwarting the accomplishment of simple tasks such as washing or cooking. These events could result in patients either becoming aggressive or protesting by refusing to cooperate with staff. Either way, the patient ran the risk of being forcibly restrained and isolated and, for a moment, enabling the staff to feel effective in their ways of coping with the impossible work tasks. Patients had to deal with considerable frustrations and to accept their diagnosis on pain of forced treatment, restraint or isolation. Thus good patients “toed the line”, were able to suppress their frustration and contain emotional reactions and were encouraged to be passive by waiting for long periods for their needs to be met. The staff aspired to provide care and good treatment, however, much of their work actually involved physical control and containment. This extract from the field notes describes one incident where Winston, one of the patients, was blamed for having eaten all the cakes:

I wandered in and sat down to see what lunch was like. There were packs of sandwiches thrown on a serving shelf. Normally, the patients had to get them out of a bin liner but today they had been taken out of the bin liner they came in because [the nurse] used it to take the lunchtime cakes away. She did this, she said, “because Winston had them all yesterday”. In fact, he had served them to patients and staff. Today, he was in the dining room and she was humiliating him by saying this loudly in front of other patients. (Field notes, Week 1, day 4)

Blame was attributed around the system as patients were held responsible for poor treatment results, staff blamed for the poor quality of care, managers blamed for poor service facilities and, ultimately, policy makers blamed for poorly conceived and funded policy (author/s). However, there was an overall commitment to a failing mental health policy. Demands on

staff escalated and the organization remained blinded to the unworkability of such idealized policies and the emerging problems.

Willshire (1999) suggests that managing mental health services is particularly problematic because the work itself (managing mental health) involves importing madness into the system and then attempting to impose rational work structures to deal with it. She also notes the tendency to search for ideal institutions, treatments or solutions that will eradicate madness. However, the idealized state could not be realistically achieved. In this instance in-patient services, whilst relocated, changed very little from asylum care (Willshire, 1999). Blind spots must therefore become institutionalized in the system because the system itself depends on them since they are concerned with the difficulty and ultimately the inability to distinguish between the roles of reformed institution and the asylum. Defences available from bureaucratic structures in both systems enabled staff to protect themselves from contact and contamination by note writing, ordering supplies or structured contacts with patients that avoided emotional connections (Bain, 1998), which was not dissimilar to Menzies's observations from more than forty years ago.

Organizational blind spots: Towards an alternative understanding of escalation of commitment

The three vignettes from the NHS health services in England illustrate why and how certain organizations develop blind spots, which prevent them from acknowledging the sources of their difficulties thus leaving them more likely to commit to failing strategies.

Sleesman et al's, (2012) meta-analysis of research conducted over the last 35 years noted key project and psychological determinants of escalation of commitment. However the authors

also argued that research has yet to take account of structural and social factors indicated in this study (Sleesman et al., 2012). This article goes some way towards addressing this gap. It elucidates the systemic mechanisms that cause organizations to commit to failing strategies, which may seem irrational but which express the unconscious needs and demands of their members and their potential clients as well. Although it speaks to the literature on the escalation of commitment, the paper is more concerned with the persistence of escalation of commitment and specifically its social embeddedness rather than simply with its emergence. This, we suggest, can be best understood by drawing on the body of theory that places unconscious affective dynamics at its center.

The first contribution emerging from the psychodynamic conception of blind spots is the conception of escalation of commitment as an affective process connecting organizational, systemic and individual levels. Unlike previous affective explanations for escalation of commitment, it introduces a view of failure that goes beyond tangible losses and threats to self-esteem, to explain that the loss that must be averted is the loss of an idealized image of the organization and the affect management function that such images serve. In other words, the escalation is socially embedded, but there is more at stake than an impression management dynamic as suggested by extant literature (see for instance Brazerman & Neal, 1992; Wong & Kwong, 2007). Escalation of commitment then can seem to be about the maintenance of an 'ideal' on behalf of others as well as the self, through unconscious affective dynamics.

An important implication of our contribution therefore concerns the inability of power holders and/or policy makers to recognize the origins of blind spots in overly ambitious policies, as well as their own emotional investment in these policies. The size of problems

like managing madness and the prestige associated with grand projects such as the National Program for IT, play a crucial role in blinding key power holders such as senior management and/or policy makers by creating enormous pressure to demonstrate success, often fed by public scrutiny. This pressure and the attendant riskiness of the endeavors can trigger a reversion to unconscious mechanisms for affect management which can propagate throughout the social system. Thus, in contrast to cognitive approaches which assume that more deliberate forms of affect management are involved in the escalation of commitment, we offer a view in which affect plays a crucial role but is much less subject to conscious recognition and control. Such intensification of commitment to a chosen course of action, driven by a desire to avoid humiliation associated with failure (Staw & Fox, 1979), may lead to greater and greater material losses.

The second contribution we make concerns the exact mechanisms through which blind spots develop, as elaborated with our three examples from the NHS in England. These examples illustrate how susceptibility to blind spots can occur when idealized projects are proposed, which cannot be realistically implemented within the given timeframe, resources available, or without reconciling the needs and demands of all relevant stakeholders. The creation of blind spots occurs when the capacity to integrate reality has been undermined via excessive idealization. Idealization of one's own actions and the values associated with specific projects supports pervasive denial of undesirable realities at an institutional level. It is therefore both a concomitant and a necessary defensive reaction that offers comfort and enables disconnection from difficult emotions when desirable outcomes fail to materialize.

Maintaining a policy as an idealized 'good object' under such circumstances may require a psychological splitting off of any evidence of failure in which undesirable elements of

organizational reality are projected into 'bad' objects in order to shield strategists from contact with operational difficulties. Splitting and shifting the blame for any potential failures away from the self, which is the next step in establishing blind spots throughout the organization, are indispensable for maintaining the fantasy that desirable policies and organizational objectives can materialize if inconvenient aspects of reality are avoided. Splitting can then develop as a socially sanctioned defence against anxiety, and ultimately become enacted in physical divisions between parts of the system or organization, as was seen in each of our three examples. Specifically, the first (IT) example illustrated how splitting between policy designers and implementers could lead to the downfall and eventual abandonment of a large-scale project. In the second example of individualized patient choice, splitting between patients and health care providers allowed for the possibility of attaining policy goals to go unchallenged. The final example we presented illustrated how blame for the inadequacies of de-institutionalization policies was transferred (via the staff) to the patients themselves. However, blaming distorts reality and is a substitute for meaningful action to resolve problems. Blame is also counterproductive, as it is not about learning from experience but simply provides temporary relief from undesirable and overpowering feelings of failure, as shown in the mental health example.

Our third and final contribution is to highlight the influence of higher level social dynamics on the individual psychology that enables escalation of commitment. The proposed theory of the development and institutionalization of blind spots elucidates the dynamics that lead to their formation and originate in unrealistic policies expressing unconscious demands of policy makers and their constituencies at the system level. Thus if we consider that these unrealistic policies are put in place on behalf of a broader social desire for organizations to neatly address large and intractable problems then the defence mechanisms of idealization,

splitting and blame that organizations deploy do not merely 'allow' them to continue to remain committed to unworkable strategies: in fact, the unworkable policies 'demand' that organizations remain committed to those strategies. This explains their persistence which often makes the escalation of commitment inevitable. Put differently, because social defences are often inbuilt in public policies, the intensification of commitment becomes institutionalized by the development of organizational blind spots as areas of reality distortion and avoidance, which prevent realistic evaluation of organizational performance.

The concept of organizational blind spots we advance explains escalation of commitment from a novel perspective. That is, it links systemic and individual levels and shows how the intensification of defensive mechanisms is constantly required to, at least temporarily, avert acknowledgement of loss or failure. As shown in our examples, this is often achieved by cutting off decision makers and various parts of the organization tasked with the implementation of complex and important projects from the source of potential distress. When this happens, there may be insufficient consideration of important sources of difficulty. Importantly, the aspirations that policies come to express often go relatively unchallenged as they fulfill societal desires of the public and organizational members alike to believe in the idealized organization. Although the concept of 'blind spots' may imply a concern with long-term organizational functionality, we wish also to draw attention to the 'disowned subjectivity' by citizens who project their aspirations onto public institutions (Hoggett, 2006). Policy goals are often ambiguous and sometimes also contradictory, because public organizations serve as 'a receptacle for containing social anxieties' (Hoggett, 2006:177). Such links to the systemic level, and the consideration given to affective attachments by which societal aspirations find their way to policies and strategies, eventually becoming internalized and enacted by individuals and groups in organizations, represent a major

contribution to the original theory of socially sanctioned defences against anxiety that was proposed by Menzies and Jacques.

In sum, we contribute by proposing an innovative approach to understanding dysfunctions of policy implementation in public organizations. Our theoretical stance is consistent with emergent psychosocial approaches to studying policy environments and the organizations implementing them. To date, policy research has offered limited accounts of why unrealistic projects occur in the public sphere even though persistent commitment is not uncommon in public policy (see Dickinson & Sullivan, 2013; Fotaki, 2010; Gunder, 2010). We highlight the role of defences against anxiety, which are unconsciously held, deeply engrained and maladaptive, in the development of blind spots. The three NHS examples suggest to us that the capacity for splitting and idealization is particularly facilitated when institutions such as governments take responsibility for health care, allowing individuals to escape anxiety about their own unconscious fears related to infirmity and mortality. Health care organizations are especially prone to idealization as they set out to save lives and reduce suffering, but realistically cannot fully achieve their ideal.

Conclusions

Whilst the difficulties of policy implementation have long been recognized, we explain how separation between policy formation and implementation enables policy makers to become unrealistic and idealistic while operational staff are neither able to implement these unrealistic policies nor to have their difficulties heard. The process of articulating impossible policies and the difficulties involved in implementing them are all underscored by social defences around working in health care (Fotaki, 2010). This, we have suggested, leads to multiple affective investments and responses in organizations, which are generated by both,

the reality of implementing of unrealistic policy, and the recognition that such policies are doomed to fail. Yet while we must remain aware of the various psychological functions that public organizations play for wider society, we suggest organizations in the larger commercial sector are not immune to the processes we have described as they conceive of themselves existing for the social good.

We have proposed an alternative explanation as to why organizational strategies may so easily become divorced from organizational practice having a detrimental effect on organizational functioning and performance that is a result of the escalation of commitment to failing courses of action. In exploring three health service examples taken from the NHS in England, we have demonstrated why and how splitting in the system (mostly between policy and its implementation) enables idealization of the task and its turning it into an aspirational grand project causing organizations to abandon the task they have been created to fulfill. Examples of splitting and blame underpinning such dynamics have been outlined to illustrate how these processes are self-defeating as they do not enable critical review of organizational difficulties; while they may offer temporary relief problems remain unsolved and the organization must work all the harder to sustain these splits leading to the creation of blind spots.

One final point concerning the concept of blind spots we propose is about its distinctiveness from complex cases of 'perverse blindness' that Long (2007) has theorized by examining business and commercial institutions. Drawing on a different organizational example from mental health care services, Rizq (2013) supports her argument by demonstrating how the NHS 'market for care' turns a blind eye to the emotional realities of suffering, particularly in mental health services as one of our vignettes has shown. The 'virtual reality' where attention

to targets, outcomes, protocols and policies is privileged over attention to the patient's psychological needs has led to the perversion of care. This raises important questions about conditions enabling policy makers to blind themselves to the predictable effects of their own actions. This issue, and the enabling role of their constituencies in making such outcomes possible, could be a subject of the future psychosocial research agenda on public policy outcomes in diverse organizational settings other than the health care examples discussed here.

Counteracting blind spots generated by idealization, splitting and blame in organizations is both possible and desirable. But how might they be overcome? In therapeutic terms, recognition of unconscious processes can start a journey towards realism, although this carries the cost of giving up idealized objects. Certain factors encourage re-integration. As in psychotherapy, where the bringing to consciousness of previously unconscious material allows for reconciliation and changed behaviors, organizations can become aware of counterproductive forces and actions. The three examples clearly show that certain groups within the organizations (e.g. clinicians or patients) are often painfully aware of the difficulties. However, when their voices are cordoned off through splitting and blame, their input may not be heard or acted upon. Moreover our examples show that when policies fail to deliver, the blame is, often mistakenly, shifted onto different parts of the organization, groups of operational workers or external bodies. Only when something like the Challenger disaster occurs do we suddenly realize with painful clarity the interdependencies and links between the persons on whom we project heroic properties and the management and administration that serves them (Krantz & Gilmore, 1990). A more desirable, integrative response by top decision makers is to recognize warnings as unwelcome news but an inescapable aspect of reality, rather than solely a sole source of anxiety. Tendencies towards using social defences

to maintain collective self-esteem can possibly be overcome through reflexive questioning in the process of organizational learning (Brown & Starkey, 2000). Understanding how splitting, idealization and blame operate in organizational systems can aid their understanding and acceptance. Increased awareness of maladaptive defences that impede effective operation might enable re-integration of crucial sources of necessary but unpleasant information in organizational practices. Rather than offering predictive tools, psychodynamic techniques presented here, allow for appreciation of these aspects of organizational realities and elucidation of the work of social defences on a systemic level. By unearthing these dynamics, we hope this article encourages reflexive questioning of blind spots and how they may contribute to the escalation of commitment to failed causes.

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[Please insert – Author biogs – many thanks]

Corresponding author:

Marianna Fotaki,
Centre for Public Policy and Management
Manchester Business School
Booth Street
West Manchester
M13 6PB

T: 0161 2752908 / 0161 9287460

F: 0161 2735245

and

Warwick Business School
Coventry
United Kingdom

Marianna.Fotaki@wbs.ac.uk

Other author:

Paula J Hyde

proxy

University of Durham

Durham

United Kingdom

paula.hyde@durham.ac.uk